Report to Virginia's SFRP Advisory Committee: Compendium of Evidence-based, Best, and/or Promising Practices

Report to Virginia's SFRP Advisory Committee: Compendium of Evidence-based, Best, and/or Promising Practices

Prepared by Kari Demetras, M.Ed, Consultant Liaison, NCSACW

INTRODUCTION

This report is intended to provide the Virginia team with information that will assist the strategic planning workgroups and the Executive Team in establishing goals and objectives for improving daily practice and creating systemic change related to families in the child welfare system that are involved with substance abuse problems – particularly those with children placed in out-of-home care. The information presented here is by no means exhaustive, and should be considered as guidance based on what is already happening in other parts of the nation, and even within the state. There is a wealth of information on best, promising, and evidence-based practice that exists, and this report attempts to capture a snapshot of that information within its narrative, as well as provide references to guide those interested in conducting more involved exploration. The report highlights practices related to collaboration and systems integration as the "first order of business", and follows this section up with individual sections on practices related to child welfare, substance abuse, and the courts.

It should be noted that the section on the courts is the most abbreviated, for the simple reason that the majority of "best/promising practice" information related to model courts has been developed by the National Council of Juvenile and Family Court Judges, and is contained on their website, which is referenced herein. The narrative itself notes that Virginia has a significant number of model courts within its borders, and is clearly very aware of the components that characterize "best practice".

COLLABORATION AND SYSTEMS INTEGRATION

Policy Issues. Policies must be free of punitive aspects and the personal biases of policy makers. The literature is full of tales of the most troubled families being singled out for punitive intervention, while other less troubled families, engaging in identical behaviors, are not. We are primed to see low income and low status families differently than high income and high status families. Populations believed to be the cause of most of the child abuse and substance abuse are targeted for research related to that abuse, while studies of non-abusing parenting are normally done on affluent white families. There becomes a cycle, where the bias leads to surveillance, which leads to detection, which influences research that influences policy (Colby & Murrell, 1998). This cycle of bias leading to policy must be interrupted.

Policies must support the increase in improving the health of mothers and their children through better assessments and increased treatment and other services. Policies must support the inclusion of fathers, as well. Even though single parenthood is predominantly a female phenomenon, the fathers can still be important for the intervention. Policies must address the effects and impacts of the abuse on the individuals, not singling out and targeting certain drugs themselves. It is not coincidence that the drugs being singled out as the "bad drugs" are often those being used by low-status families. Polices must address the personal beliefs and characteristics of the actual helpers and other providers of service. Team case management can best handle issues of culture, past use, and past family history.

Increase capacity. A review of existing data suggests that, although a high percentage of parents in the welfare and child welfare systems need alcohol- or drug-related treatment, these services are provided to only a fraction of them. Even some biological parents who receive a variety of services are not able to have their children returned to them, due to the relatively short length of the delivery

of the services compared to realistic drug treatment time frames (Linares, 1998).

Collaboration and Blending of Services. Different systems need to resolve the separate and conflicting services they deliver to a family or individual. Purposes, goals, philosophies, time frames, staff education, funding steams, values and legal mandates all need review and consistency over the many systems in order for a continuum of services to be effective with families (Azzi-Lessing & Olsen, 1996; Young & Gardner, 1998; Colby & Murrell, 1998). These services should be from a broad spectrum of fields, including: public and private agencies, AOD treatment, mental health, health care, education, housing, vocational and employment, child welfare.

Laura Feig (1998) describes several components that need to be present in a true collaboration across systems. These components require system changes of a large nature.

- joint system training
- team staffing
- joint funding
- joint goal setting
- jointly sought treatment milestones and outcomes
- improved family risk assessments
- delivery of services as a single package
- use of a parenting focus to treatment and to child welfare services
- integrating child development services into treatment
- provide long-term services
- do prevention work with the children while the caregiver is in treatment

Blending Disciplines, Integration and Collaboration. Drug problems are not isolated, and they are usually only one of the difficulties the family is struggling with. It is clear that the designation of a "drug problem" as the issue is narrow and superficial. For effective blending of services, it is recommended that we reach well beyond typical enforcement and drug prevention strategies, for example, to proposals for fundamental restructuring of community involvement in prevention and in treatment (Weinstein, et. al., 1991). Many disciplines need to be involved, including social services, public health, mental health, education, housing, law enforcement and the courts (Wallen, 1999).

Providing integrated collaborative services is like going from the traditional two-dimensional to the three-dimensional game of Scrabble. Plans and services can and should be a complex interweaving of individual, family, neighborhood services of prevention and intervention. Like the three-dimensional Scrabble, this blending of another dimension opens up so many new opportunities to address the needs by building on the strengths. Bloom (1998) suggests that we must look at the whole configuration of strengths, supports and resources of the family, the social context, and the neighborhood and community environment as well as the personal, social and environmental difficulties of the individual needing services. Doing so means the challenging of sacred cows, system-specific language, traditions, institutional rigidities and categorical funding.

Parent education, family therapy, and respite care are services that need also to be considered. Family therapy and family-based psychoeducational services are effective strategies to add to traditional AOD treatment (McCreary, et. al., 1998).

Although budgetary constraints for long-term child services are considerable, a larger barrier is that society does not like to think about the long-term management of drug-related child abuse, regardless of the prospects for success. Making commitment to these families means addressing the concomitant real and multiple needs (Besharov, 1996). When services are blended, the societal negative response to drug abuse is reduced by including treatment with an array of other services.

Over the last 10 years, a record number of single-parent families have entered the child welfare system because of the mother's substance abuse. Several elements must be present in order to address this problem (Azzi-Lessing & Olsen, 1996): Services must be comprehensive and well coordinated; staff from all systems must be cross trained in other systems, to be able to understand and make appropriate referrals; practice must be empowerment-based, working toward helping families and also solving environmental issues; helpers must support the development of self-efficacy in families and individuals; policies, procedures and agreements among systems must allow sharing of needed information and methods to solve problems and overcome barriers; there must be a full continuum of services, that are family-centered and home-based for some families; women-centered services must be available, involving the participation of children in the services; and services must be individualized.

Changes in attitudes, knowledge, and skills are required of both the child welfare and the substance abuse treatment worker. These two systems must combine their perspectives to address both the mother's recovery and the child's well-being (Tracey & Farkas, 1994). Many of the interrelationships of the wide variety of service settings (child protection services, primary health care providers, social service settings, legal system, vocational rehabilitation systems and employment settings) encountered by substance abusers were studied by Rose, et. al. (1999). Their analysis identified the same challenges and barriers to the current system of service, and suggests areas for development of nearly identical "best practices".

Case Management. With the effort to collaborate and blend service delivery to families, good case management becomes more than just seeing that the case plan gets written and implemented. Case management, when done in a collaborative and intensive manner, can greatly improve success measures for treatment success and post-treatment maintenance (McLellan, 1999; Greenfield, 1997). With intensive case management, individuals and families receive more, and a wider variety of, services while in treatment than do people without case management. That increase in services can result in improved outcomes following treatment. Use of AOD can be reduced significantly; furthermore, people are more likely to show improvement in employment, family relations, emotional and health functioning, and legal status.

A new title for case management might be "service coordination". This title more accurately reflects the roles and responsibilities of someone in this relationship with a family. Helping the providers coordinate their services, so as to be complimentary and appropriate, is a difficult task. It takes someone who can help bridge the differences among the various systems and phase the services so that they are not all being delivered at the same time.

Community Based Services. Resnick (1998) outlines many of the elements of community- and neighborhood-based components and services to succeed. First of all, the services should be for the family, not just an individual. They must be comprehensive, and clearly be focused on positive outcomes. Foster care, if needed, should be part of the constellation of neighborhood supports, with the children placed for short term in the neighborhood. The community should focus on increasing the protective factors, decreasing the risk factors, and building child and family resiliency. Families should be fully involved as partners. The effort should be community-wide.

In Baltimore, one program takes treatment to the high-risk neighborhoods in a bus, partnering with churches to use their parking lots. In Rancho Cucamonga, CA, a treatment program partners with the YMCA, where adolescent participants get substance abuse treatment and free access to all the YMCA's facilities (DPRC, 2000). These are two examples of innovative ways communities and treatment programs can work together.

Cross-Disciplinary Training. When either a child protection worker or a substance abuse treatment provider is working with a client, it is sometimes difficult to know when to bring in the other agency. A key factor in assuring that both substance abuse and child protection issues are addressed is making sure that workers (from both agencies) are trained to look for and identify both problems in families served (U.S. Department of Health and Human Services, 1999). Successful cross-disciplinary training efforts include involving professionals from all involved disciplines early in the process; implementing needs assessments to assure curricula address the needs of the target populations; employing intensive outreach and recruitment of potential trainees; and involving both management and line staff.

With the passage of ASFA, cross-disciplinary training curriculum must include information about ASFA timelines, how decision-making timeframes have changed, and the implications for practice and treatment. It also might include effective parenting and family interventions, engagement and retention of clients in treatment, relapse management, and post-treatment support. Some sources of cross-disciplinary training curricula include:

Multidisciplinary training curricula from Children's Bureau grantees: In 1997, the Children's Bureau of the U.S. Department of Health and Human Services issued 10 three-year grants to universities affiliated with public child welfare agencies to develop and implement interdisciplinary training curricula. The curricula were designed to enhance the capacity of public child welfare workers and their supervisors to respond effectively to child abuse and neglect, with particular emphasis on families experiencing problems related to substance abuse, mental illness, and domestic violence. The grantees (listed below) provide their curricula as a tool to other states or localities interested in implementing cross-systems training.

* Fordham University, Children and Families Institute for Research, Support and Training
* San Diego State University School of Social Work, Public Child Welfare Training Academy
* State University of New Jersey—Rutgers
* University of California at Berkeley, School of Social Welfare
* University of California at Los Angeles, School of Public Policy and Social Research
* University of Michigan, School of Social Work
* University of Southern Maine, Muskie Institute
* University of Utah—Salt Lake City
* University of Washington School of Social Work, Northwest Institute on Children and Families
* University of Wisconsin at Green Bay

Maryland's curriculum: Under Maryland's Title IV-E waiver demonstration program, the University of Maryland's School of Social Work provides a five-day interdisciplinary training to child welfare and substance abuse agency staff. The curriculum addresses the prevalence of substance abuse among the child welfare population; screening for substance abuse involvement; the concept of addiction as a disease, including how addiction and withdrawal affect an individual's body, behavior, and perception; the strategic use of authority to leverage parental compliance with a treatment and reunification plan; strategies for child welfare staff to work with parents in early recovery, e.g., the first 6 to 12 months; and steps for helping the parent commit to the joint goals of abstinence and safe parenting.

Contact: Ron Zuskin, LCSW-C, LCADC
Director of Training
School of Social Work
University of Maryland
(410) 706-3637

Illinois's curriculum: The Illinois Department of Children and Family Services (DCFS) developed the Substance-Affected Families Policy and Practice Training: The Path to Safety and Recovery to present DCFS' policy and practice for dealing with substance-affected families (SAFs) and substance-exposed infants (SEIs). The training consists of five modules directed at DCFS caseworkers and investigators, purchasers of services, personnel from the Office of Alcoholism and Substance Abuse (OASA) and Public Health, guardians ad litem, and judges. At the end of the five modules of training, participants should be able to use the SAF/SEI policy guide and protocol documents to understand how parental substance abuse affects child safety and parental functioning; determine the risk level and make a safety plan for the child, assess family needs and make a collaborative treatment plan; provide best practice clinical services during the intervention phases of the service plan; work with collaborators to provide continual evaluation of safety and treatment progress; and provide appropriate and timely case closure and aftercare plans. The five modules of the training are SAF/SEI Protocol Overview, the first 30 days—engagement, assessment and the family meeting, family intervention, evaluating progress in placement—reunification cases, and preparing for the termination of parental rights.

Contact: Nancy Roncancio
AODA Coordinator
Illinois Department of Children and Family Services
Telephone: (271) 524-3207

Content of Shared Information
Treatment providers' progress notes and clinical files should clearly describe the demonstrable signs of treatment progress that child welfare agencies and courts can use to inform child welfare decisions. In addition, treatment providers should provide notes that correspond with key case junctures, such as the court review timelines established by ASFA. Both agencies should agree ahead of time on the format and content of updates to ensure its usefulness.

Confidentiality
Agencies are searching for ways to overcome the issue of confidentiality so they can share relevant client information on a consistent basis. For instance, substance abuse and child welfare agencies may establish Memoranda of Understanding (MOUs) to facilitate information sharing. Likewise, service providers may establish Qualified Service Organization Agreements (QSOAs) to assure that either agency can share information on behalf of their mutual clients—sometimes even without the consent of individual clients—pursuant to federal drug treatment confidentiality guidelines. As an example, the University of North Carolina at Chapel Hill developed a compact disc and online training on the Federal Confidentiality Regulations Dealing with Substance Abuse Patient Records (42CFR, Part 2). This electronic course offers interactive video, audio, text and testing technologies. It can be accessed at http://unc.blueshoe.com/course.asp.

Joint Formal Policies, Procedures, and Protocols
The child welfare agency and substance abuse service providers can establish policies, procedures, and protocols to improve working relationships. For instance, one critical protocol to support a child welfare/substance abuse collaborative would address the ongoing exchange of information—especially confidential information—about mutual clients, such as by establishing QSOAs. Confidentiality policies might establish the process to obtain consent from the client at the time of referral to share treatment information between the agencies. They also might address the circumstances under which the substance abuse treatment agency will notify the child welfare caseworker of a relapse. Another key protocol might provide guidance about when to return children to their families when substance abuse is involved. For instance, since early recovery is often a risky time for reunification, a protocol might establish which supports might be employed to address those risks.

Other policies and procedures might state that each system will receive a complete record of the family's history and current situation before making any permanent decisions; how each system will be involved in parent/child visitation; and who has responsibility for providing post-treatment supports for families and children at the community level (Blunt, 1999). The Illinois Department of Children and Family Services (DCFS) and the Office of Alcoholism and Substance Abuse (OASA) of the Illinois Department of Human Services have an interagency agreement that establishes how each agency will work with the other pertaining to child welfare clients with substance abuse issues. Through its Title IV-E waiver demonstration program, DCFS provides funds to OASA to pay community substance abuse treatment providers for services to DCFS clients. The interagency agreement establishes that DCFS clients receive priority admission and enhanced services in these community treatment agencies. In addition, the interagency agreement allows DCFS and OASA to use a jointly developed, standard release of information for sharing information on mutual clients throughout the life of a case. The interagency agreement also outlines the monthly reporting format for substance abuse treatment providers to submit information on mutual clients. A major future interagency effort in Illinois includes the creation of a joint database between DCFS and OASA to share histories on mutual clients.

Safety Planning

With the parents, the child welfare and substance abuse agencies create a safety plan (potentially at a family conference or other early-in-the-case meeting involving all stakeholders) which addresses what steps the parent(s) will undertake to care for the children in the event of a relapse. Since relapse is probable—especially if a client never has attempted to become clean and sober before—child welfare and substance abuse agencies might create a relapse assessment tool to be incorporated into a safety assessment and plan (Blunt, 1999). In addition, since the period immediately following treatment is associated with increased risks to children returning home, professionals from both systems should focus on safety planning during this period. Concurrent planning may not explicitly mandate that addicted parents obtain treatment as a condition of reunification. Nonetheless, it requires that parents receive up-front, clear disclosure regarding the consequences of their lack of participation or progress in resolving the issues that led to the initial maltreatment.

CHILD WELFARE - RELATED

Child welfare practitioners should have several perspectives when attempting to assess and work with families of color they serve. Those perspectives include: competence in ethnically sensitive practice, differences in power, variations in role, and looking at alternative approaches for helping clients who have difficulties with alcohol or drug use (Rooney & Bibus, 1996).

Neighborhood, Self-Help, and Natural Helpers Approaches

Children are not safe enough when we rely solely on the child welfare system to protect them. Funding levels vary from locality to locality, and even with unlimited financial resources, there is no assurance that such reliance would be effective. All stakeholders in the community (e.g. child welfare services, substance abuse treatment, neighborhood associations, religious bodies, community organizations, mental health, domestic violence, criminal and juvenile justice, family members and citizens) are responsible, and necessary, to protect children. While the child welfare system has primary responsibility for the safety and permanency goals of children with abuse and/or neglect or at-risk of, and their families, such efforts even when more efficient, are still attempting to resolve already existing problems. All child and family serving systems, as well as the other stakeholders in the community are needed in order to assure each child is safe, healthy, happy and educated; that each family has improved their well-being.

The self-help movement is well known, well respected, and available in most locations around the country (Riessman & Gartner, 1996). These groups are composed of people who have the same problem or life experience, to support each other, provide information, and enhance skills for coping. They are self-directing, rarely keep membership rosters or information about the group itself, or data. Alcoholics Anonymous, Narcotics Anonymous, Mother's Against Drunk Driving, Parent's Anonymous are four of many hundreds of such groups focused on the individual. There are also community self-help groups, such as neighborhood associations, community development corporations, and community centers. Investment clubs, community lending circles and Time Dollars are examples of what are known as economic self-help groups. The common denominator is that all self-help groups are built on self-improvement through mutual aid-of the individual, the family, the neighborhood or community.

Many people in all of these formal and informal systems recognize that working together and learning from each other would positively impact the safety of children and the well being of their families. With a change in policy and procedures for the many systems, working together in this capacity would not mean the extra time now piled on top of the heavy workloads those systems already have.

Title IV-E Waiver Demonstration Program States

Under the Title IV-E waiver demonstration program, four states are addressing substance abuse within the child welfare population. In fiscal years 1998 and 1999, the U.S. Department of Health and Human Services gave priority consideration to demonstration approaches designed to improve the child welfare system's response to families with substance abuse problems. Four states currently implementing Title IV-E waivers to address child welfare and substance abuse are:

Delaware: One of the first child welfare agencies to receive a Title IV-E demonstration waiver, Delaware uses a multidisciplinary team model to address parental substance abuse as it relates to cases where children are placed in foster care or are likely to enter foster care. Specifically, contracted substance abuse counselors work with child protective services workers in each of the state's three county child welfare offices. Substance abuse counselors accompany child protective workers on initial visits, and together they assess the substance abuse problem and its effect on parenting. The counselor may conduct a substance abuse evaluation or arrange for one, and the counselor stays connected with the family throughout treatment. The substance abuse counselors participate in the Division of Family Services' (DFS) two-month new worker training, and then receive follow-up training throughout their tenure. In addition, child welfare caseworkers receive a three-day overview on the impact of alcohol and other drugs on individuals, as well as the indicators that a person may be abusing substances. Savings in foster care caseloads, pursuant to the waiver demonstration, pay for the counselors.

In addition, DFS and the Division of Substance Abuse and Mental Health implemented a joint Memorandum of Agreement (MOA) which requires substance abuse treatment providers who serve DFS clients to honor confidentiality issues; share information within the parameters of those rules; and follow a standard format for the content and submission of progress reports to both state agencies. The MOA also explicates that a provider must see a referral within 72 hours and provide written reports within two weeks. Finally, the MOA states that neither state agency can close a case without first meeting on the issues and clients' progress. Delaware's "one judge, one child" model also ensures judicial oversight and support of parents' treatment and progress in addressing the issues that brought them to the attention of the child welfare agency.

Contact: Joanne Bruch
Delaware Division of Family Services

Telephone: (302) 633-2690

Illinois: The Illinois Department of Children and Family Services (DCFS) contracts with a local treatment provider for addictions specialists called recovery coaches to assist families early in their treatment process, and to continue to provide support to families during and after treatment to prevent relapse and facilitate reunification. The process to link recovery coaches with child welfare clients begins long before a formal relationship develops. During the period when a DCFS caseworker first contacts a family, the DCFS workers implement a substance abuse screening of their clients; both DCFS and the Illinois Office of Alcoholism and Substance Abuse jointly developed this screen and trained caseworkers on its use to ensure it captures substance abuse issues pertaining to child welfare clients. If a screen indicates a parent has a problem with substance abuse, the caseworker documents this fact and refers the parent to treatment.

In addition to treatment, at the 90-day judicial hearing the court and the DCFS caseworker strongly encourage parents to obtain a more complete assessment of substance abuse issues; assessment providers are located in the same building as the Family Court to facilitate the transition from court to services. A recovery coach—certified by the Illinois Alcohol and Other Drug Addiction Professional Counselors' Association—is present at the assessment site and makes initial contact with the parents there. The recovery coach offers support services in addition to traditional child welfare and substance abuse treatment services. If the family accepts, then the recovery coach follows up in cooperation with the DCFS caseworkers and the family's treatment provider, with specific staffings among these stakeholders at every critical case juncture, e.g., six-month administrative case review or the period immediately before children are returned home. Once the children are returned home, the court may require that recovery coaches continue services to address associated stresses and the potential for relapse. To ensure that the recovery coaches and DCFS workers understand the services each provides, recovery coaches receive the same risk assessment training as DCFS caseworkers, and caseworkers receive AODA training.

The next stage of the waiver demonstration program will allow families in the second demonstration group to receive an enhanced array of services in addition to recovery coach services. Enhanced services include medically managed detoxification and withdrawal services, drug-free housing, graduated sanctions, reunification and concurrent planning consultation, and home visiting nurses.

Contact: Rosie Gianforte
Coordinator, Title IV-E Waiver AODA Project
Division of Health Policy
Illinois Department of Children and Family Services
Telephone: (312) 814-2440

Maryland: The state is providing services to substance-abusing caretakers to prevent unnecessary out-of-home placement and expedite family reunification. Family support services teams, comprised of addictions specialists, local Department of Human Resources staff, treatment providers, parent aides, and mentors provide comprehensive, coordinated services to families of children at risk of foster care placement or who already are in foster care due to parental substance abuse. Upon referral and if the parents exhibit an interest in obtaining help with their substance abuse, an addictions specialist implements a modified Cage Questionnaire assessment tool to assess the level of parental substance abuse and its impact on child welfare.

Parents with substance abuse and child welfare concerns are then assigned to one of three community-provided treatment options: inpatient treatment for parents and their children; intermediate 28-day residential care; or intensive outpatient treatment. Treatment providers additionally provide wraparound services including case management; individual, group, and family therapy; obstetrical or gynecological care and family planning clinics; HIV education and testing;

relationship groups; parenting skills training; domestic violence and sexual assault survivor groups; housing; employment; child care; and transportation.

Contact: Wayne Brewster-McCarthy
Social Services Administration, Maryland Department of Human Resources
Telephone: (410) 767-7991
E-mail: wbmccart@dhr.state.md.us

New Hampshire: The Title IV-E demonstration project in New Hampshire involves contracting with a licensed alcohol and drug abuse (A&D) specialist who also is certified in family therapy. The A&D specialists are stationed in each DHS field office and work with the child protection service workers on a consultant basis, providing training, information, and recommendations regarding treatment. Once a CPS worker identifies potential substance abuse issues in a family referred for abuse or neglect during the initial risk and safety assessment, she or he refers the family to an A&D specialist. The A&D specialist approaches the family, obtains their approval to proceed—along with the appropriate releases of information—and implements a modified version of the Substance Abuse Self-Evaluation Inventory (SASEI) to caretakers to determine the extent to which substance abuse impacts parental capacity to provide adequate care and supervision of the children. Furthermore, this assessment informs the Department of Children, Youth, and Families (DCYF) of the A&D specialist's recommendations regarding safety and case plans and current or future treatment needs once the court substantiates a case for abuse or neglect.

Since so many cases in New Hampshire are unsubstantiated, the A&D specialists also may provide up to 60 days of intensive substance abuse services for child abuse or neglect cases that are referred but not substantiated to mitigate the potential for future risk. If a case is substantiated, the SASEI is part of the case record and thus the court also may use it to tie a client's substance abuse needs to treatment plans. In addition and implemented prior to the Title IV-E demonstration project, New Hampshire's court system and DYCF jointly created a protocol in which the court specifically states to the client the consequences of not meeting the terms of the case plan, including accessing substance abuse treatment.

Contact: Bernard Bluhm
Division of Children, Youth and Families
New Hampshire Department of Health and Human Services
Telephone: (603) 271-4440
E-mail: bbluhm@dhhs.state.nh.us

Edna McConnell Clark Foundation's "Community Partnerships for Protecting Children" Sites
The Edna McConnell Clark Foundation currently funds four Community Partnerships for Protecting Children sites that provide child protective and other services directly to the communities where they are located, including varying degrees of substance abuse treatment. The sites are:

Jacksonville, Florida: The Jacksonville Community Partnership for the Protection of Children program addresses four overlapping issues that are present in the majority of Florida's Department of Children and Family (DCF) child abuse and neglect cases. These issues include child abuse and neglect, substance abuse, mental illness, and domestic violence. When the DCF's CPS worker receives an allegation of child abuse and neglect, the worker assesses the potential for these four issues. If any are present, the worker refers the case to the Community Partnership for the Protection of Children to provide appropriate referrals and follow-up services. In July and again in October 2001, DCF workers joined staff from the substance abuse, mental health, and domestic violence fields for cross-training on these issues as well as appropriate interventions.

With specific regard to substance abuse, the Jacksonville office of the Department of Children and Families deploys staff to the local substance abuse treatment agency, Gateway Community Services. This substance abuse professional accompanies the CPS worker to provide support to the family, and attends follow-up family team meetings to offer additional referrals and guidance on substance abuse treatment. Every person attending the family team meeting signs a form promising confidentiality; the form also provides a release of information to allow information sharing among the treatment agencies providing services to the family. Florida has adopted the Community Partnership for the Protection of Children model and currently is replicating it in five additional DCF sites in Jacksonville, as well as other sites around the state. The original local Community Partnership site is assessing whether it will incorporate with the new DCF sites, or if it will create a stand-alone nonprofit agency.

Contact: Sandra Durham, Director
Joan Martin, Administrative Assistant
Jacksonville “0809” Community Partnership for the Protection of Children
Telephone: (904) 924-1680

Louisville, Kentucky: In Louisville, the Clark-funded Community Partnership for Protection of Children (CPPC) site is named UJIMA. It is here that a substance abuse case manager has been co-located with CPS staff to provide services. Some of the duties performed by the substance abuse case manager are assessments, screenings, and referrals to appropriate treatment modalities and services for clients who meet certain criteria. It may be determined through an initial screening that a client may not need services provided by a substance abuse case manager for substance abuse treatment but may require other social services help. This outcome of the assessment is communicated to the referral sources and follow-up case management or monitoring is provided as prescribed.

If a client is referred to treatment, a treatment plan or service plan is developed to assist the client and family. Within the framework of the plan, we identify client strengths and barriers to recovery. The case manager helps the client with issues regarding maintaining abstinence, child care, housing (transitional and permanent), transportation, employment, vocational rehabilitation, medical issues, and legal problems. The case manager collaborates with other service providers in meeting client and family needs. The case manager provides advocacy for the client (e.g., attending family court sessions to facilitate reunification of parent and children once the client is viewed as stable) and will report to the referring agency if the client is noncompliant with the treatment or service plan. The case manager maintains involvement until the client no longer seeks services or no longer complies.

The substance abuse case manager at UJIMA participates in outreach undertakings and events within the community such as health fairs and other type of forums. Staff are also available to consult with faith-based or other social service entities to include substance abuse related curriculum in their endeavors to reach others affected by substance abuse. Staff also collaborate with other CPPC components such as a domestic violence prevention and community resources team to help in their efforts. The case manager attends regular Neighborhood Place UJIMA, CPPC, and other related meetings and is cochair of the family focus work groups. The manager also takes part in all forums and services sanctioned by the CPPC. The case manager provides education and consultation in the areas of substance abuse treatment and recovery to all UJIMA staff and community members who desire it.

The substance abuse case manager will also facilitate any referrals for family members to services when warranted. The staff encourages clients and family members who are affected by addiction to seek support through Alcoholics Anonymous, Narcotics Anonymous, ALANON, or NARANON as recovery is an ongoing process. The staff also promotes any positive activity that supports the emotional, spiritual, physical, and mental well-being of clients and family —church, exercise,

education. UJIMA features an on-site program for 6-12 year olds that helps children understand dynamics of addiction and recovery and lets them know they are not alone. The program is called Children of Addicted Parents Program (CAPP) and runs concurrently with NA meetings at UJIMA.

Contact: Barbara Carter
Neighborhood Place UJIMA
Telephone: (502) 595-5643
Keith Vandeveer, CADC
CPPC at Neighborhood Place UJIMA
E-mail: kvandeve@sevencounties.org

Cedar Rapids, Iowa: In response to the prevalence of prenatal exposure to illegal substances, staff at area hospitals, the Iowa Department of Human Services (DHS), and community agencies created the independent Children at Risk Task Force. The task force is funded by the Partnership for Safe Families, Iowa's self-titled program funded by the Clark Foundation's Community Partnership for the Protection of Children grant. The task force consists of administrators from the Iowa Department of Human Services and two hospitals, and local treatment providers, including the Heart of Iowa, a residential treatment program for mothers at risk of losing their children due to substance abuse. The task force meets monthly to coordinate services for newborns who test positive for illegal substances, and it meets every other month to address community issues related to child welfare and substance abuse. DHS makes all referrals of child welfare clients with substance abuse problems to community treatment programs, some of which employ community family support workers under the rubric of the Partnership for Safe Families.

The community family support workers provide such support services as parenting skills, homemaker services, and money management. DHS caseworkers collaborate with community family support workers, and both types of worker can implement a safety plan with a client family. Either type of caseworker may refer families to the task force for family team meetings to address substance abuse and safety issues. In July 2001, the task force held a substance abuse and child welfare cross-training for 97 staff from DHS, the Partnership for Safe Families, the Task Force for At-Risk Children, and treatment provider agencies not already included in those groups. DHS also uses a multidisciplinary team agreement with any agency involved on the task force to facilitate information sharing and address confidentiality issues regarding mutual clients. The agreement is signed at the beginning of a case and amended as new agencies enter the service spectrum.

Contact: Hailee Sandberg
Children at Risk Task Force Facilitator
Family Services
100 1st Street, SW, Suite 200
Cedar Rapids, IA 52404
Telephone; (319) 398-3574
E-mail: Hsandberg@familyservicesiowa.org

St. Louis, Missouri: The primary goal of this community partnership program is to provide CPS workers with the tools they need to recognize and help their clients address alcohol and drug abuse issues. The site employs a high-level CPS worker who also is an A&D specialist. This specialized staff person is housed in the hotline to provide front-end technical assistance workers who suspect that a referred client has substance abuse issues who present risks to his or her children. Ongoing workers also may access the services of the A&D specialist. In addition, the A&D specialist attends all 72-hour family team meetings where caretaker substance abuse is suspected. There, the specialist is a resource to the family, referring them to treatment or counseling as their case plan allows.

The A&D specialist also provides training for child welfare staff and community partners on addressing substance abuse with child welfare clients. In addition to co-locating the cross-trained A&D specialist in the child welfare agency, Missouri's departments of Mental Health and Social Services bring together their staff working with clients with substance abuse, child welfare concerns, developmental disabilities, and mental illness for a one-day interdisciplinary training. This training focuses on sharing information on each division's role and responsibilities in serving mutual clients, and offers job-shadowing opportunities so that peers can directly experience another's job. To provide immediate information to child welfare workers on community-based substance abuse treatment services, St. Louis' Neighborhood Network is creating an Internet-accessible database of available treatment slots for child welfare clients. Finally, in November 2001, St. Louis implemented its first Family Drug Court to leverage compliance with treatment and to provide intensive supervision and incentives for continued progress.

Contact: Francis Johnson
Supervisor, Child Welfare Hotline
Missouri Department of Social Services
Telephone: (314) 301-7822

ALCOHOL AND OTHER DRUG - RELATED

Promising Models, Approaches and Steps Forward

http://www.cwla.org/programs/bhd/promisingAODmodels.htm#top

From a broad base of research and service delivery experience, there is a common theme: promising family strengthening initiatives should begin a dialogue with professionals and caretakers from many different disciplines, which will lead to innovation in policies, programs, and practices at the local level. Collaborative, coordinated, culturally competent, community based services are more likely to emerge when the professionals and caregivers in a community possess a common base of knowledge about child welfare concerns and AOD problems (Wingfield, 1998). In public hearings around the country in 1999, the Center for Substance Abuse Treatment heard the same themes of coordinating assessments and providing a continuum of care that is family-focused with an array of "wraparound" services and aftercare programs (CSAT, 1999). In these hearings, there was also clear support for providing culturally relevant, gender relevant, and alternative forms of treatment.

A recent report to the United States Congress echoed this same theme in numerous parts of the report (HHS/SAMHSA, 1999). Specifically, the report recommended that prevention and intervention strategies must be:

- **Comprehensive**, integrating the contributions of social service, legal, law enforcement, health, mental health and education professionals;
- **Neighborhood-based**, strengthening the neighborhood and community by encouraging and supporting local improvement efforts, including self-help programs, that make the environment more supportive of families and children;
- **Child-centered**, protecting the safety and personal integrity of children and giving primary attention to their best interests; and

- **Family-focused**, strengthening families, supporting and enhancing their functioning, providing intensive services when needed, and removing children when such action is appropriate.

Diversify treatment. Treatment specific to the needs of women, pregnant women, different cultural groups, and home-based would improve access and appropriateness in matching client needs with treatment options.

McMahon and Luther (1998) recommend that we open our minds to new options of meeting the needs of substance abusing parents and their children. They recommend seven structural components to a family-oriented drug abuse treatment program:

1) Prenatal intervention,
2) Child care services,
3) Family therapy,
4) Parent intervention (education),
5) Child development services,
6) Specific interventions for children, and
7) Interagency collaboration.

Issues of culture, gender, age of the children, parent drug of abuse, and the treatment setting all need to be considered in the actual services to be delivered. A network of agencies, co-located, with multiple points of entry should be part of the design of such a treatment program.

Models That Show Promise

The Opportunity to Succeed (OPTS). This treatment model (Rossman, 1998) was developed in a multi-site demonstration program that helped addicted ex-offenders break the cycle of recidivism and become contributing members of their communities. The program served felons (who were not convicted of rape or murder) who received substance abuse treatment while incarcerated and assisted them in re-establishing their ties to their communities, families and jobs. The core of the program was the close relationship between the participant, the community-based case managers and the parole or probation officer. Local case management ensured that participants received continuing drug treatment, family counseling, medical and mental health care, assistance in finding housing, and employment training; virtually everything they needed to make the transition to community life. The program was operated in St. Louis and Kansas City, Missouri; Tampa, Florida; and West Harlem, New York by a public/private partnership of correctional and social service agencies.

Another successful approach to this population is using contingency management to enhance client motivation (Silverman, 1999; Higgins & Silverman, 1999). Using a combination of positive and negative reinforcements and positive and negative punishments, studies have found that reinforcements are generally more effective in motivating change than punishments. The well-established principles of operant learning are highly applicable to client elimination of drug self-administration. Program elements recommended include: 1) make the program and consequences very clear; 2) use a foolproof system to detect use; 3) aim at relatively brief periods between consequences; 4) use a consequence controlled by the helper; and 5) make the consequences numerous, initially small, and predictable. The study further found that while contingency management can help a person gain a long period of abstinence, it is no better than other interventions in preventing relapse. It does, however, give the person more time in abstinence to develop other relapse prevention strategies. A variety of studies using contingency management have shown significant positive effects in getting and keeping IV drug users in treatment, helping pregnant women stay in treatment at higher rates, having longer periods of abstinence in alcohol and cocaine abusers and those with co-occurring mental health disorders. "A challenge for

contingency management practitioners . . . may be to change prevailing concepts of what treatment is, of how it is delivered, and of how one searches for optimal treatments."

CASAWORKS. In January 1999, The National Center on Addiction and Substance Abuse at Columbia University (CASA, 1999) launched CASAWORKS for Families, a three-year demonstration to help drug and alcohol addicted mothers on welfare achieve self sufficiency. CASAWORKS combines in a single concentrated course of treatment and training: drug and alcohol treatment, literacy and job training, parenting and social skills, violence prevention, health care, family services and a gradual move to work. The program is being tested at 11 sites in nine states, including New York and California, and will serve more than 1,100 women and their children. While the effort is too new to show any results, it does blend a wide array of services into a single "service", which addresses many of the difficulties in separate systems working, at times, at cross purposes with each other.

La Bodega de la Familia. This is a program in New York City that includes the addicts' families in the drug treatment process (DOJ, 1998). In response to evidence that substance abusers supported by a caring family are more successful than others in completing treatment, the city opened this program. It uses family case management, with a focus on the whole family and helping friends, not just the addict, building on their strengths. La Bodega identifies the most appropriate treatment and other providers for referral and coordination, and many of the services are provided in the homes and neighborhoods of the participants. They assist the families with access to the Internet, and information about health, housing, mental health, job training, housing and employment services.

CSAT Model Program. The Center for Substance Abuse Treatment has developed a comprehensive treatment model for AOD abusing women and their children. In summary, it establishes both program structure and administration, as well as clinical interventions and other services to be provided. It is prepared in a manner to allow for local adaptation.

Sobriety Treatment and Recovery Teams. The Cuyahoga County (Ohio) Department of Child and Family Services operates START, an adaptation of a similar program in Hamilton County, Ohio, called ADAPT. START is an attempt to meld together what is known about addiction services treatment, good child welfare practice and family preservation practice into a model that can work with the special needs of these families. The population targeted for this program is crack cocaine-using women with children in the Child Welfare system. A set of tenets for blended work with these families is included in Appendix B. Unique to this program is the pairing of a Child Welfare Social Worker and an Advocate who is a former substance abuser, and often a parent in the child welfare system. These two share the traditional child welfare roles, with smaller caseloads (15 families maximum) and a great deal of cross training in child welfare, AOD treatment and family preservation. Equally involved are several drug treatment providers, who also receive the cross training. Health and mental health care providers, housing programs, family and friends, and other supports are part of the family team to support the successful outcomes of the unified plan for the mother. (Annie E. Casey Foundation, 1998).

One part of this network of treatment agencies includes the program called Miracle Village. This is a recovery community for addicted women and their children in a public housing environment. After 4 years of operation, 63% of the women who completed initial treatment are sober and living in the area.

Strategies for Family Change. This is a Sacramento County (California) Department of Health and Human Services response to the population of substance abusing child welfare families. Building on an existing substance abuse treatment initiative, SFC conceptualized a network of formal and informal supports surrounding families to keep children safe. Formal and informal supports are located within the neighborhood, where various disciplines are housed together, and work together.

Help is available before problems continue to escalate in severity. Two existing neighborhood centers began the effort, with a third being added in 1999. Each center was different, including the array of services existing in the neighborhood. See Appendix C for a description of and picture of the SFC model. (Annie E. Casey Foundation, 1998A).

Maternal Addiction Program. MAP is a combination residential and day treatment program, in Miami, developed to meet the needs of a largely African American, inner city, indigent female population who are pregnant (Calley & Murell, 1998). In this program, the women start in residential treatment for 28 days, and then go into day treatment for a period from 6 to 12 months, depending in needs. The services target drug use with benefits to the mother and children for reaching and maintaining abstinence. They coordinate with child welfare, social services, legal and other community resources, childcare, transportation and parenting programs. A cross-trained multidisciplinary team, with the mother, develops the specifics of a tailored intervention plan.

Prevention. The Center for Substance Abuse Prevention has developed a booklet describing the eight most successful drug abuse prevention programs (CSAP, 1999). Some of these programs are aimed at children and youth, and often based in school settings. Others are community-based, in churches or other community-based organizations, and target families. One is a program targeted to youth in residential placements. The National Institute on Drug Abuse (NIDA, 1997) developed a guide with prevention principles to help in the development of prevention programs that are community-based, school-based or family-based. This same guide describes other successful prevention programs around the country. These two sources provide a wide range of ideas and models for alcohol and drug abuse prevention.

Frontline Practice Level

In this section, we will discuss specific approaches, methods and tools, which have been found to improve family functioning and reduce AOD abuse and child abuse.

Client-Worker Relationship. Interview data from mothers in substance abuse rehabilitation who were regaining custody of their children were analyzed to identify social worker and agency characteristics that facilitated their recovery and family reunification (Akin and Gregoire, 1997). Findings were grouped into three categories: 1) the addiction experience, where the worker understood the omnipresent and overwhelming impact of drug use, even when the person really wants to be clean; 2) lack of the usual system shortcomings-changing the paternalistic actions by workers that reinforce parent powerlessness, cynical agency attitudes and unrealistic expectations; and 3) system successes that encouraged addiction knowledge, provided direction, shared power between parent and worker, and built a relationship based on trust and availability. Implications for practice include the importance of developing a supportive and helpful client-worker relationship and that the worker uses the power of the system to help the family, not to coerce it.

Empathy on the part of the interviewer is a high predictor of positive outcomes in treatment (Fiorentine & Hillhouse, 1999). Accurate empathy has been known for many years to be the most important characteristic of the helper in the helping relationship (Miller, 1992).

Social Support. A body of research and writing describe the importance of social support for women to enter, remain in and follow-up to treatment. One study found that increased social support was significantly associated with increased self-esteem, a key factor in moderating depression and in successful treatment outcomes (Dodge & Potocky, 2000). They recommend that increased social support be a component of treatment and follow-up care.

Family Strengthening, Self-Efficacy Building. Family strengthening refers to efforts that engage the individual and family in the planning and implementation of services, particularly those services

which build on existing family strengths and meet their particular needs. In one study, the quantity of services, which matched the clients' belief that the services were relevant to their situation, was a statistically significant predictor of length of stay in treatment; moreover, length of stay in treatment correlates positively with improved treatment outcomes (Dilonardo, 1998). The results may suggest that an additional important pathway to improving treatment outcome is meeting client's perceived needs.

A node-link map is a cognitive-behavioral visual representation and communication technique (Newbern, et. al., 1999). It increases motivation and self-confidence (self-efficacy) to employ behavioral skills cited as outcomes of positive treatment. It also increased the ability of the client to use oral and written communications while in treatment. Findings suggest that substance abuse treatment is enhanced by service delivery that incorporates clients' perspectives and addresses their interrelated drug abuse problems (Quimby, 1995).

Parenting is often the only role women see as legitimate in their life, and that their children are a stabilizing influence (McMahon & Luther, 1998). Their child abuse or neglect can also lead them to feelings of guilt, shame and failure due to their substance abuse. Programs that work to maintain the parent-child relationship can use this parent role strength to help in raising motivation to address the drug use. The acquisition of the parent role was linked to reduced drinking on the part of women in one study (Crum, et. al., 1998). When the child welfare system places children, it should be for only enough time to get treatment started. Returning the children, with the proper supports and services, can actually help the mother maintain the progress made. Without the proper supports and services, the added stress of the parent role can have a deleterious effect.

Culture and Gender Considerations. Women in early recovery often experience problems related to parenting, to trauma resulting from physical or sexual abuse, or to mental illness. Recovery will be more likely successful if these other issues, which precipitate or relate to the abuse of alcohol or other drugs, are attended to. Remaining drug free is very difficult if the woman remains in an abusive relationship, if she has no coping skills to deal with her children, if she has no access to counseling, is in unsafe housing, or her and her family's basic needs are not being met. Ongoing counseling, self-help and other supports, and accessibility to other available resources are almost required in order to maintain recovery (HHS/SAMHSA, 1999).

Gender and ethnic congruity between client and interviewer increases client disclosure; however it does not necessarily increase client retention in treatment or treatment outcomes (Fiorentine & Hillhouse, 1999). The helper must also have empathy skills, to help the family members build their sense of hopefulness and ability to succeed with their goals.

Specialized AOD treatment programs have been developed in the recent past for women (Grella, et.al., 1999A). These women-only programs differ from traditional mixed-gender programs in a number of areas: inclusion of children, treatment that is focused on relationships, addressing past trauma from abuse, sexual abuse and domestic violence. Further, since so many of the women have been unemployed, job readiness is often an included service. The process and duration of the treatment itself is more flexible with this population. Many of these programs allow the (young) children to be with the mother, in both outpatient and inpatient programs.

COURT- RELATED

PRACTICE IMPROVEMENTS PIONEERED BY MODEL COURTS

"*Model Courts: Improving Outcomes for Abused and Neglected Children and Their Families* published by the National Council of Juvenile and Family Court Judges, Reno, Nevada." ©2004, National Council of Juvenile and Family Court Judges.

- Establishment of one judge/one family calendaring.
- More substantive preliminary protective hearings.
- Scheduling hearings at a specific time ("time certain").
- Implementation of strict no-continuance policies.
- Copies of orders disseminated to all parties at the end of each hearing.
- Setting the date and time of the next hearing at the end of the current hearing.
- Development of "dedicated" attorneys.
- Improved advocacy for children and representation for parents.
- Development of data information systems specifically focused on dependency case processing.
- Faith community involvement.
- Development of family group conferencing and dependency mediation programs.

IMPROVED OUTCOMES ASSOCIATED WITH MODEL COURTS

In Chicago, the backlog of children under court jurisdiction in out-of-home, long-term foster care was reduced from an estimated 58,000 to fewer than 20,000 during a three-year period. The number is now less than 16,000 children. The implementation of improved practices in the juvenile courts reduced the length of time a child remained under the jurisdiction of the juvenile court by 50% and reduced the time children remained in out-of-home care from 400 to 178 days. The savings were estimated at $5 million.

In Des Moines, through the utilization of mediation programs, the number of contested removal hearings has been reduced by more than 50 percent. "Parties come to court less polarized, having already developed a working relationship with providers and agency workers prior to court involvement," states Lead Judge Connie Cohen.

In Alexandria, the Model Court is cooperating with the Virginia Director of Court Improvement to establish "Best Practice Courts" throughout Virginia. There are currently 19 courts participating. Each court is using the *RESOURCE GUIDELINES* and the examples of the Model Court to engage their communities and agencies in making changes to impact the lives of children and families.

In Salt Lake City, utilization of the same best practices has produced similar results, and children are able to have safe, permanent homes in a shorter time.

In San Jose, the adoption rate doubled. San Jose also created one of the first child welfare mediation and family group conferencing programs in the United States; the San Jose program is now a nationally recognized model and is an expected part of best practices.

REFERENCES

American Public Human Services Association (APHSA): www.aphsa.org

Annie E Casey Foundation: www.aecf.org

Center for Substance Abuse Treatment (CSAT):
http://www.samhsa.gov/centers/csat2002/csat_frame.html

Child Welfare League of America (CWLA) -
http://www.cwla.org/programs/bhd/promisingAODmodels.htm#top

Connecting Child Protective Services and Substance Abuse Treatment in Communities: A Resource Guide – 75 pg guide available online at http://www.aphsa.org/cpssubabuse.pdf

National Center for Substance Abuse and Child Welfare - http://www.ncsacw.samhsa.gov/resources.asp

This website contains resources and publications pertinent to the issues of substance abuse, child welfare, tribes, and family judicial systems, including the following:

* Safe & Sound: Models for Collaboration Between the Child Welfare & Addiction Treatment Systems
* Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection
* Healing the Whole Family: A Look at Family Care Programs
* No Safe Haven: Children of Substance-Abusing Parents
* Foster Care: Agencies Face Challenges Securing Stable Homes for Children of Substance Abusers
* Responding to Alcohol and Drug Problems in Child Welfare: Weaving Together Practice and Policy
* Linking Child Welfare and Substance Abuse Treatment: A Guide for Legislators, August 2000, National Conference of State Legislators.

National Council of Juvenile and Family Court Judges - Permanency Planning for Children Department http://www.pppncjfcj.org/html/publications.html This website contains the following on-line resources:

* Resource Guidelines: Improving Court Practice in Child Abuse and Neglect Cases (170 pg guide)
* Adoption and Permanency: Improving Court Practice in Child Abuse and Neglect Cases (152 pg guide)
* Community and Cultural Considerations in Child Abuse and Neglect Cases: National Judicial Curricula Series – Court, Agency and Community Collaboration
* Court, Agency and Communities Working Together: A Strategy for Systems Change National Judicial Curricula Series-Court, Agency and Community Collaboration

Opportunities for Collaboration Across Human Services Programs, published June 2003, discusses the interdependence of major human service programs administered at the state and local level. 79-page report can be found online at: http://www.aphsa.org/EBOpaper.pd